STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. BUILDING _____ B. WING _____	C 08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On site investigation conducted to investigate complaints # 24816, 25154, 25537, 25985, and 26190. No deficiencies were cited related to complaints # 24816, 25154, and 25537.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 1. Order was received for Resident #7 for Megace after notifying physician of recommendation. — 05/27/10 2. All other identified weight loss residents assessed. No other residents found to be affected. — 08/11/10 3. Dietician will place recommendations needing follow up directly on MD notification board. RN House Supervisor to then notify physician within 24 hours of receiving recommendation. — 08/16/10 4. ADON to monitor MD notification board and subsequent orders daily for appropriate follow-up on dietician recommendations. — 8/19/10 ~~08/16/10~~ and on-going 9/9/10 11:55 AM Changes to POC made with permission of Doug Ford, Adm. Mary Ann Dyke RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas S. Ford — TITLE: NHA — (X6) DATE: 8/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to timely notify the physician of the Registered Dietician's recommendation for an appetite stimulant for one (#7) with a decline in intake of eleven residents reviewed. The findings included: Resident #7 was admitted to the facility on November 9, 2009, with diagnoses including CVA, Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), Hypertension, Anemia, Arthritis, Vitamin B12 Deficiency and Senile Dementia. Medical record review of the Minimum Data Set dated May 30, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; required extensive assistance with eating; was totally dependent on staff for all other activities of daily living; and had no weight loss. Medical record review of the resident's weight loss record revealed the following weights: November 11, 2009-121.5 lb. (pound) and May 14, 2010-119.5 lb. (two lb. weight loss or 1.6%). Continued review of the weight record revealed on June 2, 2010, the weight was 95.5 lb., a twenty-four-pound weight loss in nineteen days (20% weight loss). Medical record review of a dietary note dated May 21, 2010, revealed a family member expressed concern related to "intake had declined." Continued review of the dietary note dated May	F 157	See page 1 of 15	

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F 157	Continued From page 2 21, 2010, revealed the Registered Dietician (R.D.) recommended an appetite stimulant. Medical record review of a physician's order dated May 27, 2010, revealed, "Megace 400mg (milligrams)...qd (every day) x (times) 30 days." Interview on August 10, 2010, at 2:05 p.m., in the medical records room, with the R.D. confirmed the family had expressed concern on May 21, 2010, that the resident's intake had declined and confirmed on May 21, 2010, the R.D. had recommended the resident be given an appetite stimulant, and the stimulant was not ordered by the physician until May 27, 2010, six days later. Interview on August 11, 2010, at 1:35 p.m., on the unit, with the Registered Nurse (RN #2) charge nurse confirmed no documentation the physician had been notified, prior to May 27, 2010, of the recommendation by the R.D. for the appetite stimulant.	F 157	See page 1 of 15	
F 279 SS=D	CO #25985 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	See page 4 of 15	

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F 279	Continued From page 3 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the care plan to include total assistance of two people for transfers using a mechanical lift for one (#8) of eleven residents reviewed. The findings included: Resident #8 was admitted to the facility on May 7, 2003, with diagnoses including Severe Syringomyelia (chronic progressive disease of the spinal cord), Compressive Cervical Myelopathy (pathological condition of the cervical spinal cord), Spinal Stenosis, Spastic Cervical (C5) Quadraparesis, Chronic Neuropathy, Anemia, Epileptic Seizures and Coronary Artery Disease. Medical record review of the Minimum Data Set dated June 25, 2010, revealed the resident had no short or long-term memory impairment and moderately impaired decision-making skills; was totally dependent on staff for bed mobility, transfers and all activities of daily living; required manual lifting for transfers; and had partial loss of range of motion in both hands, arms, legs and feet.	F 279	F 279 1. Resident #8's Careplan reviewed and corrected. 2. All other residents identified as requiring total assistance of 2 with a mechanical lift careplans reviewed. No other residents found to be affected. 3. In-Service with the licensed nursing staff to incorporate details regarding proper updating of careplan including staff required for safe mechanical lift transfers. 4. Routine monitoring to be completed by the MDS/Careplan team including the reviewing the careplan for identified specific requirements for safe resident transfers being clearly identified on the careplan. DON & ADON conducted inservice	08/16/10 08/18/10 08/26/10 08/26/10 and on-going

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F 279	Continued From page 4 Medical record review of a Nursing Summary Report dated April 21, 2010, revealed, " ...Total assist of two required for transfers et (and) bed mobility. Sit-to-stand mechanical lift used d/t (due to) resident refusal to use total lift ..." Medical record review of the care plan updated May 28, 2010, revealed the care plan did not include the requirement for two person assist for transfers using a sit-to-stand mechanical lift. Interview on August 10, 2010, at 3:10 p.m., in the medical records room with the Assistant Director of Nursing (ADON)/Falls Management Coordinator confirmed CNA #1 (Certified Nursing Assistant) transferred the resident from the chair to the bed on May 11, 2010, without assistance using the sit-to-stand mechanical lift, and the resident fell from the bed to the floor. Medical record review and interview on August 10, 2010, at 3:50 p.m., in the medical record room, with the ADON/Falls Management Coordinator confirmed the care plan had not been updated to include the requirement for two persons to transfer using a mechanical lift. C/O #25985	F 279	See page 4 of 15	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	See page 6 of 15	

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to provide a two-person transfer using a sit-to-stand mechanical lift, resulting in a fall, for one (#8) of eleven residents reviewed. The findings included: Resident #8 was admitted to the facility on May 7, 2003, with diagnoses including Severe Syringomyelia (chronic progressive disease of the spinal cord), Compressive Cervical Myelopathy (pathological condition of the cervical spinal cord), Spinal Stenosis, Spastic Cervical (C5) Quadraparesis, Chronic Neuropathy, Anemia, Epileptic Seizures and Coronary Artery Disease. Medical record review of the Minimum Data Set dated June 25, 2010, revealed the resident had no short or long-term memory impairment and moderately impaired decision-making skills; was totally dependent on staff for bed mobility, transfers and all activities of daily living; required manual lifting for transfers; and had partial loss of range of motion in both hands, arms, legs and feet. Medical record review of a Nursing Summary Report dated April 21, 2010, revealed, "...Total assist of two required for transfers et (and) bed mobility. Sit-to-stand mechanical lift used d/t (due to) resident refusal to use total lift..." Medical record review of a Post Falls Nursing Assessment dated May 11, 2010, revealed, "...CNA (Certified Nursing Assistant) placed	F 323	F323 1. Staff member involved in transfer on 05/11/10 educated regarding appropriate transfer technique with this resident. 08/11/10 2. All residents identified as requiring 2 person assist with a mechanical lift transfer assessed. No others found to be affected. 8/18/10 3. In-Service with all nursing direct care givers including education regarding where to find information for specifics of safe transferring needs of their residents. 08/26/10 4. During routine rounds nursing supervisors and QA staff will monitor mechanical lift transfers for safety in technique. 08/26/10 and on-going DON & ADON conducted inservice.	

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F 323	Continued From page 6 resident on bed with sit-to-stand device. CNA went to lay resident on the bed, pulling feet up and resident leaned forward instead of laying down. CNA attempted to catch resident's fall to the floor...Resident hit forehead on trash can and obtained an abrasion on forehead. Skin tear to left elbow. CNA called for assistance and another CNA assisted to pick resident up and place...in wheelchair..." Medical record review of an x-ray report dated May 11, 2010, revealed, "No radiographic evidence of acute fracture or dislocation...Mild osteoporosis..." Medical record review of a nurse's note dated May 27, 2010, at 10:00 a.m., revealed, "L (left) knee swollen, tender to touch. MD (Medical Doctor) notified..." Medical record review of a nurse's note dated May 27, 2010, at 10:30 a.m., revealed, "...Send to hospital..." Medical record review of x-ray results of the left knee dated May 27, 2010, revealed, "Acute fracture of the distal shaft of left femur...Mild osteoporosis..." Interview on August 10, 2010, at 3:10 p.m., in the medical records room with the Assistant Director of Nursing (ADON)/Falls Management Coordinator confirmed CNA #1 transferred the resident on May 11, 2010, without assistance using the sit-to-stand mechanical lift, and the resident fell from the bed to the floor. Continued interview with the ADON revealed the resident refused to be transferred to the hospital after the fall, and a mobile x-ray revealed no acute fracture. Continued interview with the ADON revealed the resident reported a "popping" sound	F 323	See page 6 of 15	

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F 323	Continued From page 7 in the left leg on May 27, 2010, while being dressed, and an x-ray obtained on May 27, 2010, revealed an acute fractured left femur. Continued interview with the ADON revealed the ADON requested a re-read of the May 11, 2010, x-ray due to concern the resident may have had a hairline fracture on May 11, 2010. Telephone interview on August 10, 2010, at 3:40 p.m., with CNA #1 (who transferred the resident on May 11, 2010, with a sit-to-stand mechanical lift at the time of the fall) confirmed CNA #1 transferred the resident without assistance from the chair to the bed using the sit-to-stand mechanical lift. Continued interview with CNA #1 confirmed CNA #3 was in the room, "talking to me" but was not assisting with the transfer of the resident at the time of the fall. Continued interview with CNA #1 revealed CNA #1 "felt" the fracture occurred during the transfer because the resident's feet and knees were on the floor after the fall, and after the fall, the resident continually complained the left leg was "uncomfortable." Continued interview with CNA #1 revealed the resident "repeatedly refused to go to the hospital" after the fall. Interview on August 11, 2010, at 1:45 p.m., on the unit, with CNA #2 confirmed CNA #2 had been assigned to the resident "in the past" and had transferred the resident using the sit-to-stand mechanical lift. Continued interview with CNA #2 confirmed two people were required for transfer of the resident, one to lift the feet and legs and one to hold the shoulders. Interview and observation on August 11, 2010, at 2:05 p.m., revealed the resident lying in bed. Observation revealed the left leg had been	F 323	See page 6 of 15	

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F 323	Continued From page 8 amputated above the knee and revealed severe contractures of the right leg and both arms. Interview with the resident revealed CNA #1 had transferred the resident from the chair to the bed using the sit-to-stand mechanical lift, without assistance, and the resident fell from the bed to the floor. Continued interview with the resident revealed the resident "believe" the fracture of the left knee occurred at the time of the fall from the bed. Telephone interview on August 12, 2010, at 9:55 a.m., with CNA #3 confirmed CNA #3 was in the room on May 11, 2010, when CNA #1 transferred the resident with the mechanical lift, and the resident fell from the bed to the floor. Continued interview with CNA #3 confirmed CNA #1 transferred the resident without assistance using the sit-to-stand mechanical lift. Telephone interview on August 16, 2010, at 11:40 a.m., with the Radiologist who read the x-ray dated May 11, 2010, confirmed a fracture of the left femur was not evident on May 11, 2010. Continued interview with the Radiologist confirmed the x-ray which was obtained on May 27, 2010, revealed a displaced fracture of the left distal femur. Continued interview with the Radiologist revealed, after a re-read of the x-ray dated May 11, 2010, the Radiologist could not confirm the fractured femur had occurred on May 11, 2010. C/O #25985	F 323	See page 6 of 15	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325	See page 10 of 15	

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F 325	Continued From page 9 resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a timely re-weigh and initiate timely administration of an appetite stimulant for one resident (#7) with a decline in intake of eleven residents reviewed. The findings included: Resident #7 was admitted to the facility on November 9, 2009, with diagnoses including CVA, Dysphagia (difficulty swallowing), Aphasia (difficulty speaking), Hypertension, Anemia, Arthritis, Vitamin B12 Deficiency and Senile Dementia. Medical record review of the Minimum Data Set dated May 30, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; required extensive assistance with eating; was totally dependent on staff for all other activities of daily living; and had no weight loss. Medical record review of the resident's weight loss record revealed the following weights: November 11, 2009-121.5 lb. (pound) and May 14, 2010-119.5 lb. (two lb. weight loss or 1.6%).	F 325	F325 1. Resident #7 placed on the NIP program 05/03/10, staff attempted to feed the resident, appetite stimulant was initiated 05/27/10 and resident was re-weighed 06/02/10. 2. Residents identified by the dietician with weight loss or on the proactive weight loss list reviewed. No others identified as being affected. 3. In-Service to be complete with weight staff and dietician regarding communication and follow up on identified potential weight loss residents. 4. Weekly meeting to be conducted by the dietician with the weight staff to review all weights requested/obtained over the previous week. Continue Monthly multidisciplinary weight loss meetings. DON + ADON conducted the inservice.	05/03/10 05/27/10 06/02/10 08/16/10 08/23/10 08/23/10 And On-going

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F 325	Continued From page 10 Continued review of the weight record revealed on June 2, 2010, the weight was 95.5 lb., a twenty-four-pound weight loss in nineteen days (20% weight loss). Medical record review of a dietary note dated May 3, 2010, revealed the resident was placed in the facility's nutrition intervention program (NIP) for additional calories and protein with each meal. Review of the facility's NIP revealed, "...The following will be added to the patient's diet: Morning (-) "8 ounces fortified cereal, 8 ounces whole milk, and 1 tablespoon melted margarine, added to appropriate food"; Noon (-) 8 ounces whole milk, 1 tablespoon melted margarine, added to appropriate food... Replace starch on menu with fortified version"; Evening (-) "8 ounces whole milk, 1 tablespoon melted margarine, added to appropriate food, 6 ounces fortified cream soup or other appropriate fortified food, i.e. ice cream, pudding...Note: The fortification of food normally served...adds approximately 1000 calories and approximately 15-20 grams of protein to the meal plan..." Medical record review of weekly skin assessments dated April 4, 2010-May 24, 2010, revealed the the resident's average intake of meals was 75% (percent) or more. Medical record review of a dietary note dated May 21, 2010, revealed a family member expressed concern related to "intake had declined." Continued review of the dietary note dated May 21, 2010, revealed the Registered Dietician (R.D.) recommended an appetite stimulant and a nutritional supplement twice daily with the medication pass.	F 325	See page 10 of 15	

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F 325	Continued From page 11 Medical record review of a physician's order dated May 27, 2010, revealed, "Megace 400mg (milligrams)...qd (every day) x (times) 30 days." Interview on August 10, 2010, at 2:05 p.m., in the medical records room, with the R.D. revealed the resident's weight had been stable from admission until June 2, 2010. Continued interview with the R.D. confirmed the family had expressed concern on May 21, 2010, that the resident's intake had declined and confirmed on May 21, 2010, the R.D. requested a re-weigh of the resident. Continued interview with the R.D. confirmed the resident was not re-weighed until June 2, 2010, (nineteen days later) at which time the resident had a twenty-four-pound weight loss from May 14, 2010. Continued interview with the R.D. confirmed the R.D. had recommended on May 21, 2010, the resident be given an appetite stimulant, and the stimulant was not ordered by the physician until May 27, 2010, six days later. Interview on August 11, 2010, at 8:50 a.m., in the medical records room, with Registered Nurse (RN) #1 revealed the resident "use to sit in the hall and work on feeding (self). I would offer and he would say 'No'!" Continued interview with RN #1 revealed, "As far as we could determine... (resident) was eating 75% or more." Medical record review of the weekly skin assessment record dated April 4, 2010-May 24, 2010, and continued interview with RN #1 confirmed the resident's intake of meals was 75% or greater. Interview on August 11, 2010, at 9:20 a.m., in the medical record room, with the Restorative Certified Nursing Assistant (RCNA) revealed the RCNA attempted twice to place the resident in the facility's restorative dining program, but the	F 325	See page 10 of 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. BUILDING _____ B. WING _____	C 08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12 resident refused. Continued interview with the RCNA revealed, "I would try to feed, but (resident) was trying to do it...would not let you feed (him/her)." Telephone interview on August 11, 2010, at 2:55 p.m., with the facility's former R.D. who initially placed the resident in the NIP on May 3, 2010, revealed, "I know the meal intake was adequate secondary to the Albumin (level) was up, and the weight was stable. The albumin being up and the weight being stable indicates (resident's) nutrition was stable." Continued interview with the former R.D. revealed the R.D. "would observe a meal and supplement acceptance...frequency of observation would depend on the resident." Continued interview with the R.D. revealed the R.D., "I base intake adequacy on lots of parameters and not just on how much a person is eating. I look at it collectively."	F 325	See page 12 of 15	
F 514 SS=D	CO #25985 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	See page 10 of 15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the administration of medications, as ordered by the physician, was accurately documented on the Medication Administration Rercord for one (#11) of eleven residents reviewed. The findings included: Resident #11 was admitted to the facility on June 2, 2010, with diagnoses including Atrial Fibrillation, Acute Respiratory Failure, Diabetes Mellitus, Chronic Gastric Ulcer, Hypertension, Anxiety, Mouth Ulcer and Constipation. Medical record review of the Minimum Data Set dated June 5, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; required extensive assistance with bed mobility, transfers, dressing and hygiene; required limited assistance with eating; was continent of bowel and had a urinary catheter; and had no weight loss. Medical record review of the physician's admission orders dated June 2, 2010, revealed, Bisacodyl (laxative) 5mg (milligram) every day as needed, Docusate Sodium (laxative) 100mg twice daily, Lactulose (Constipation) every day as needed, Miralax (Constipation) every day as needed, and Milk of Magnesia (Constipation) every twelve hours as needed. Medical record review of a physician's order dated June 3, 2010, revealed Miralax was changed to a scheduled dose of twice daily. Medical record review of the Medication	F 514	F514 1. Resident #11 already discharged from the facility. Documentation can not be corrected to accurately reflect administration or lack of administration of medication. 2. Current resident MARS reviewed. No others found to be affected. 3. In-service with all licensed nursing staff reviewing policy regarding proper documentation on MARS. 4. Risk Management Nurses to routinely audit MARs and Treatment Sheets for their respective floors. Pharmacy consultant to randomly complete monthly MAR documention audits for completeness. DON + ADON Conducted the inservice.	08/20/10 08/26/10 08/26/10 And On-Going

AUG 30 2010

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	445107	A. BUILDING _____ B. WING _____	C 08/18/2010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 14 Administration Record (MAR) dated June 2-30, 2010, revealed no documentation Docusate Sodium or Miralax was administered on June 4, 2010, at 9:00 p.m., as scheduled and no documentation as to why the medications were not administered. Medical record review of the MAR and interview on August 12, 2010, at 11:40 a.m., in the Assistant Director of Nursing's (ADON) office, with the ADON confirmed no documentation Docusate Sodium or Miralax was administered on June 4, 2010, at 9:00 p.m., as ordered by the physician and confirmed no documentation on the back of the MAR to indicate why the medications were not administered. Telephone interview with the Licensed Practical Nurse (LPN #1) on duty June 4, 2010, on 3:00-11:00 p.m., shift, confirmed LPN #1 was assigned to the resident on June 4, 2010, and "always signed the MAR when medications were given, and if not given ...initialed, circled and noted on the back why not given." C/O #26190	F 514	See page 14 of 15	

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